Department of Disabilities and Special Needs
Drug Test Program

Release of Information Form

As an employee of the South Carolina Department of Disabilities and Special Needs, I understand and acknowledge that I have been referred to the Employee Assistance Program conducted by the S.C. Department of Vocational Rehabilitation.

I hereby sign this waiver which releases information about the education and treatment program in which I will participate. I authorize the release of information as outlined in the Department's Alcohol and Drug Free Workplace Policy to the Human Resource Management Director of my employing agency.

I will present a copy of this signed waiver to the Employee Assistance Program counselor as notification that I am a mandatory referral under the Department's Alcohol and Drug Free Workplace Policy. I understand that if I do not meet my scheduled Employee Assistance Program assessment and complete the recommended education and treatment program that I will be subject to disciplinary action up to and including dismissal as defined under the Department's policy.

Name of Employee:_____

Division/Institution Name:_____

Employee Social Security Number:_____

_____ _____
Signature of Employee Date

_____ _____
Signature of HRM Director Date

_____ _____
Employee Refused to Sign (Witness) Date